ATTACHMENT 2

Instructions for Completion of the Physician Otological Report for Hearing Aid Evaluation
(PA/OF)

1. Complete each item on the form.

2. Give the recipient the first copy; retain the second copy for your records.

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ELEMENT 1 - PHYSICIAN NAME AND ADDRESS
Enter your name and complete address, including Zip Code.

ELEMENT 2 - TELEPHONE NUMBER
Enter your telephone number, including the Area Code.

ELEMENT 3 - PROVIDER NUMBER
Enter your eight (8) digit Medical Assistance provider number.

ELEMENT 4 - SIGNATURE AND DATE OF EVALUATION
Upon completion of your evaluation, enter your signature and date of the evaluation in this element.

ELEMENT 5 - MEDICAL ASSISTANCE NUMBER
Enter recipient's ten (10) digit Medical Assistance identification number as indicated on the current Medical Assistance Identification Card.

ELEMENT 6 - RECIPIENT'S NAME
Enter the recipient's last name, first name and middle initial as it appears on the Medical Assistance Identification Card.

ELEMENT 7 - RECIPIENT'S ADDRESS
Enter the complete address of the recipient's place of residence; if the recipient is a resident of a nursing home, enter the name and address of the nursing home.

ELEMENT 8 - RECIPIENT'S SEX
Specify if male or female with an "X".

ELEMENT 9 - DATE OF BIRTH
Enter recipient's date of birth in MM/DD/YY format (e.g., January 5, 1978 would be 01/05/78) as it appears on the Medical Assistance Identification Card.

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The remainder of the form is used to document your otological evaluation of the patient. Use additional paper if needed, attaching it to the form.

ITEM 7 (Physician's Recommendations) must be completed. Completion of Item 7 ensures that the patient is appropriately referred to a Wisconsin Medical Assistance certified audiologist or hearing aid dealer for the hearing evaluation. Forms submitted to the WMAP without a referral will be returned to the audiologist or hearing aid dealer.